

PRINTED: 10/06/2011
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN0502	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/04/2011
NAME OF PROVIDER OR SUPPLIER COLONIAL HILLS NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2034 COCHRAN RD MARYVILLE, TN 37803	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies During the Life Safety portion of the survey, there were no deficiencies cited from 1200-8-6, Standards for Nursing Homes.	N 002		

Division of Health Care Facilities

ATTEST: DIRECTOR'S OR PROVIDER/SUPPLIER/CLIA REPRESENTATIVE'S SIGNATURE

FORM

6899

BNDL21

TITLE

(X6) DATE

10/24/2011
If continuation sheet 1 of 1